

Women's Urology and Pelvic Health Center | Patient History Questionnaire

Today's Date: _____

At the Women's Urology and Pelvic Health Center, our goal is to bring you state-of-the-art care. Your answers help us better understand you and your past experiences. Your responses also help us in our research to better understand the conditions we treat. Please take your time when completing this packet and supply all information as fully as possible. If you have questions or concerns, please talk to your provider.

Name:		Date of birth:
Preferred name:		Age:
Primary phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Secondary phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
OK to leave detailed message?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to receive text message appointment reminders?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary hospital: <input type="checkbox"/> Beaumont <input type="checkbox"/> Other _____		

What is the main reason for your visit today?

Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Who lives with you? Check all that apply	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Friend/Roommate <input type="checkbox"/> Other
Education:	<input type="checkbox"/> Less than 12 years <input type="checkbox"/> Some college <input type="checkbox"/> Postgraduate degree <input type="checkbox"/> High school graduate <input type="checkbox"/> College Degree
Employment Status:	<input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled
Occupation:	
Tobacco use:	<input type="checkbox"/> Never used <input type="checkbox"/> Current smoker _____ packs per day for _____ years <input type="checkbox"/> Former smoker _____ per day for _____ years Quit date: _____

Medical History		
<input type="checkbox"/> Back Injury	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Shingles	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Bipolar disorder
<input type="checkbox"/> Chronic fatigue syndrome	<input type="checkbox"/> Epstein Barr	<input type="checkbox"/> Post-traumatic stress disorder (PTSD)
<input type="checkbox"/> Seizures	<input type="checkbox"/> Lupus	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Migraines	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Personality disorder
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> Sleep disorder	<input type="checkbox"/> Other psychological problem Type:
Other:		

Surgical History			
Surgery	Date	Surgery	Date

Family Medical History		<input type="checkbox"/> Check here if family medical history is unknown	
Check illness which has occurred in any blood relative and write relationship to you			
<input type="checkbox"/> Bladder/kidney cancer		<input type="checkbox"/> Autoimmune disease	
<input type="checkbox"/> Uterine/ovarian cancer		<input type="checkbox"/> Crohn's/ulcerative colitis	
<input type="checkbox"/> Colorectal cancer		<input type="checkbox"/> Colon polyps	
<input type="checkbox"/> Breast cancer		<input type="checkbox"/> Multiple sclerosis	
<input type="checkbox"/> Chronic pelvic pain		<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Bladder prolapse		<input type="checkbox"/> Kidney stones	
<input type="checkbox"/> Interstitial cystitis		<input type="checkbox"/> Other:	

Medications			
Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify: _____			
Medication Name (include prescription, over the counter, supplements, and topicals)	Strength or dose	Frequency	Month/year started

Urologic History	
Have you seen a urologist before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, why? _____ Urologist's name: _____	
How often do you urinate during the day ?	<input type="checkbox"/> < 30 min <input type="checkbox"/> 30-60 min <input type="checkbox"/> 1-2 hrs <input type="checkbox"/> 3-4 hrs <input type="checkbox"/> > 4 hrs
How many times do you urinate at night ?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 6+
On average, how much do you drink each day (oz)?	
Water:	Soda/pop:
Alcohol:	Coffee/tea:
Other:	
Do you have a strong urge to empty your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, are you able to get to the bathroom in time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you leak with coughing, sneezing, or laughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you wear protective pads due to urine leakage?	<input type="checkbox"/> Yes (<input type="checkbox"/> thick pad <input type="checkbox"/> thin pad) <input type="checkbox"/> No
Do you have frequent bladder or urinary tract infections? (3 or more a year)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had kidney stones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever wet the bed while asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with <i>interstitial cystitis</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
If yes: Year: _____ By whom: _____	
Did you have a <i>cystoscopy with hydrodistention</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have you been told you have <i>Hunner's ulcers</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

Gynecologic History	
Birth Control Method:	<input type="checkbox"/> Not sexually active <input type="checkbox"/> Menopause <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Female partner <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Condoms <input type="checkbox"/> Pill/patch/ring <input type="checkbox"/> Depo shot <input type="checkbox"/> Mirena IUD <input type="checkbox"/> Paragard IUD <input type="checkbox"/> Implant <input type="checkbox"/> Withdrawal <input type="checkbox"/> Spermicide <input type="checkbox"/> Diaphragm <input type="checkbox"/> None
Current gynecologist:	
Date of Last Pap smear: _____	History of abnormal pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No
Infection history:	<input type="checkbox"/> Herpes <input type="checkbox"/> HPV/warts <input type="checkbox"/> Chlamydia <input type="checkbox"/> HIV <input type="checkbox"/> Yeast <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas <input type="checkbox"/> Bacterial Vaginosis
Menstrual History (skip this section if you do not currently have menstrual periods)	
First day of last menstrual period:	Age of first period:
How many days does your period last?	How often does your period occur?
Pain with periods? <input type="checkbox"/> No <input type="checkbox"/> Before <input type="checkbox"/> During	
Bleeding is: <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light	Bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No

Obstetric History			
Number of pregnancies:		Number of births:	
Year	Birth weight	Vaginal or C-section?	Complications (including stitches, tears, infection, vacuum/forceps, unusual bleeding, gestational diabetes, preeclampsia, etc.)

Menopause History (skip this section if not menopausal)	
Menopause age: _____	Concerns about menopausal symptoms today? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:
How did you go through menopause:	<input type="checkbox"/> Naturally <input type="checkbox"/> Medication induced <input type="checkbox"/> Surgically—check all that apply <input type="checkbox"/> uterus only removed <input type="checkbox"/> uterus and one ovary removed <input type="checkbox"/> uterus and both ovaries removed <input type="checkbox"/> unsure <input type="checkbox"/> abdominal <input type="checkbox"/> laparoscopic <input type="checkbox"/> vaginal
Hormone replacement therapy?	<input type="checkbox"/> Current <input type="checkbox"/> Past (years: _____) <input type="checkbox"/> Never Type: _____

Sexual Health History	
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of first sexual activity:
Sexually active with (check all that apply):	<input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> _____
Are you satisfied with your sexual activity status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain with sexual activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any recent difficulty with orgasm or decreased libido?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
Would you like to discuss your sexual health at your visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have specific concerns regarding your sexual health, please fill out the questionnaire on page 15.

Bowel History	
Do you frequently have constipation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you leak stool or bowel contents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with irritable bowel syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience frequent diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience any rectal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen blood in/on your stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When was your last colonoscopy?	Year: _____ <input type="checkbox"/> n/a

Psychological History	
Have you ever seen a psychologist, counselor, or psychiatrist?	<input type="checkbox"/> Yes, currently <input type="checkbox"/> Yes, in the past <input type="checkbox"/> Never
History of psychiatric hospitalization(s)? If yes, please note year(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No

The following questions ask about abuse. If you have experienced abuse of any kind, please know that you are not alone. We know that abuse is widespread for women and girls, as well as men and boys. We appreciate your sharing this sensitive information with us. If any experiences like these ever come up, please know that **this is a safe place to talk about it and get help.**

Abuse History/Intimate Partner Violence Screening	
Have you ever been abused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type(s) of abuse have you experienced, and at what ages? <i>If no, please skip to the next section.</i>	
Please check all that apply:	
Physical:	<input type="checkbox"/> During childhood <input type="checkbox"/> As a teenager <input type="checkbox"/> As an adult
Verbal :	<input type="checkbox"/> During childhood <input type="checkbox"/> As a teenager <input type="checkbox"/> As an adult
Emotional:	<input type="checkbox"/> During childhood <input type="checkbox"/> As a teenager <input type="checkbox"/> As an adult
Sexual :	<input type="checkbox"/> During childhood <input type="checkbox"/> As a teenager <input type="checkbox"/> As an adult
Intimate partner:	<input type="checkbox"/> During childhood <input type="checkbox"/> As a teenager <input type="checkbox"/> As an adult
Would you like a referral for assistance or counseling? <input type="checkbox"/> Not at this time <input type="checkbox"/> Yes	

Cannabis Use	
Do you use cannabis (marijuana)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to respond
If yes, what forms of cannabis do you use? <i>Check all that apply</i>	<input type="checkbox"/> Smoking <input type="checkbox"/> Eating/Edibles <input type="checkbox"/> CBD Oil <input type="checkbox"/> Cream/Ointment <input type="checkbox"/> Other: _____
If yes, how frequently do you use cannabis?	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times a week

Alcohol Use	
How often did you have a drink containing alcohol in the past year? Consider a drink a bottle of beer, a glass of wine, a wine cooler, one cocktail, or a shot of hard liquor (like scotch, gin, or vodka)	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year?	<input type="checkbox"/> 0 drinks <input type="checkbox"/> 1-2 drinks <input type="checkbox"/> 3-4 drinks <input type="checkbox"/> 5-6 drinks <input type="checkbox"/> 7-9 drinks <input type="checkbox"/> 10+ drinks
How often did you have 4 or more drinks on one occasion in the past year?	<input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily

Pain History	
Describe your current pain:	
<i>Please rate the duration of your pain, and pain level (0-10) at each pain location below (0 = no pain 10 = severe pain)</i>	
Pelvic Pain level: /10	<input type="checkbox"/> <6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5+ yrs
Bladder Pain level: /10	<input type="checkbox"/> <6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5+ yrs
Rectal Pain level: /10	<input type="checkbox"/> <6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5+ yrs
Abdominal Pain level: /10	<input type="checkbox"/> <6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5+ yrs
Hip Pain level: /10	<input type="checkbox"/> <6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5+ yrs
Vaginal/Vulvar Pain level: /10	<input type="checkbox"/> <6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5+ yrs
What triggered this pain?	
Do you engage in any of the following activities?	<input type="checkbox"/> Yoga <input type="checkbox"/> Horseback riding <input type="checkbox"/> Spinning <input type="checkbox"/> Pilates <input type="checkbox"/> Biking <input type="checkbox"/> Weight lifting/strength training
How do you currently manage your pain?	<input type="checkbox"/> Medications <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Rest/restricting activities <input type="checkbox"/> Injections <input type="checkbox"/> Implanted device <input type="checkbox"/> Physical therapy <input type="checkbox"/> TENS unit <input type="checkbox"/> Relaxation techniques <input type="checkbox"/> Chiropractor <input type="checkbox"/> Acupuncture/integrative medicine <input type="checkbox"/> Other: _____
Pelvic Pain 0 = no pain 10 = severe pain	
What is your level of pain with vaginal insertion? (e.g., tampons, intercourse, dilator/vibrator)	0 1 2 3 4 5 6 7 8 9 10
What is your level of burning-type vaginal pain during insertion?	0 1 2 3 4 5 6 7 8 9 10
What is your level of burning-type vaginal pain after insertion?	0 1 2 3 4 5 6 7 8 9 10
What is your level of deep pain during insertion?	0 1 2 3 4 5 6 7 8 9 10
What is your level of pain at the vaginal opening during insertion?	0 1 2 3 4 5 6 7 8 9 10
Overall, what would be an acceptable level of pain for you?	0 1 2 3 4 5 6 7 8 9 10

Three most significant stressors in your life right now:
1.
2.
3.

Treatment Goals: List your primary treatment goal(s) that you hope to accomplish today:
1.
2.
3.

OAB-Q (Bother)						
During the past 4 weeks, how bothered were you by...	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. An uncomfortable urge to urinate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2. A sudden urge to urinate with little or no warning?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3. Accidental loss of small amounts of urine?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
4. Nighttime urination?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
5. Waking up at night because you had to urinate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
6. Urine loss associated with a strong desire to urinate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

OAB-Q (Health Related Quality of Life)						
During the past 4 weeks, how often have your bladder symptoms...	Not at all	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Caused you to plan "escape routes" to restrooms in public places?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2. Made you feel like there is something wrong with you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3. Interfered with your ability to get a good night's rest?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
4. Made you frustrated or annoyed about the amount of time you spend in the restroom?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
5. Made you avoid activities away from restrooms (i.e. walks, running, hiking)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
6. Awakened you during sleep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
7. Caused you to decrease your physical activities (exercising, sports, etc.)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
8. Caused you to have problems with your partner or spouse?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
9. Made you uncomfortable while traveling with others because of needing to stop for a restroom?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
10. Affected your relationships with family and friends?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
11. Interfered with getting the amount of sleep you needed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
12. Caused you embarrassment?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
13. Caused you to locate the closest restroom as soon as you arrive at a place you have never been?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Pelvic Floor Distress Inventory

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

		If yes, how much does it bother you?			
		Not at all	Some-what	Mode-rately	Quite a bit
1. Do you usually experience pressure in the lower abdomen?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Do you usually experience heaviness or dullness in the lower abdomen?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Do you usually experience a feeling of incomplete bladder emptying?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Do you feel you need to strain too hard to have a bowel movement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Do you usually lose stool beyond your control if your stool is well formed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. Do you usually lose gas from the rectum beyond your control?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. Do you usually have pain when you pass your stool?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
14. Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. Do you usually experience frequent urination?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. Do you usually experience urine leakage related to laughing, coughing, or sneezing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. Do you usually experience small amounts of urine leakage (that is, drops)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. Do you usually experience difficulty emptying your bladder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

GAD-7 (Anxiety Screening Tool)				
Over the past 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Being so restless that it is hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

PHQ-8 (Depression Screening Tool)				
Over the past 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling or staying asleep, or sleeping too much?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite or overeating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

If the reason for your visit is **not related to pain**,
you **do not** need to complete pages 10-14 of this questionnaire.

If you are experiencing pain, please complete the next 4 pages.

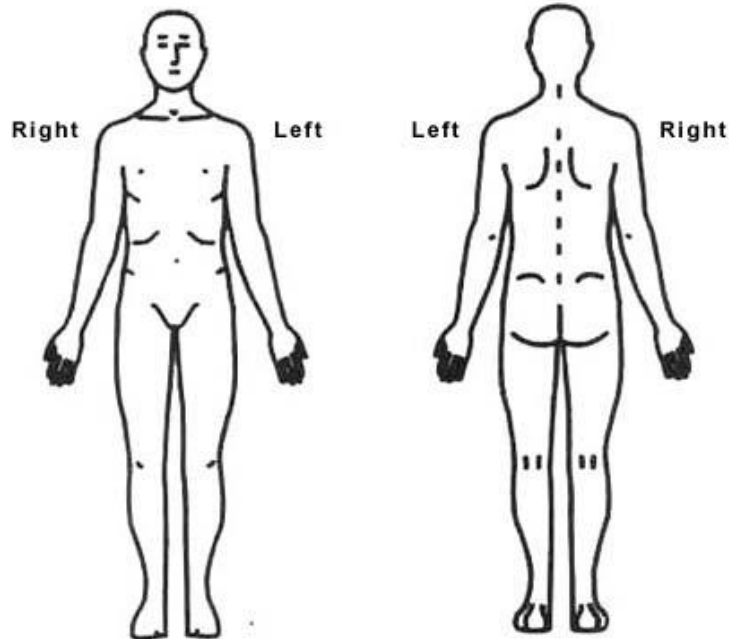
If you have concerns regarding your sexual health, please complete pages 15-17. Thank you.

Brief Pain Inventory (BPI)

1. Throughout our lives, most of us have pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-days kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on **average**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much **relief** have pain treatment or medication provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9. Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your

a. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

b. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

c. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

d. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

e. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

f. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

g. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

PCS (Pain Distress Measure)					
<p><i>Everyone experiences painful situations at some point in their lives. Such experiences may include pelvic pain, headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures, or surgery.</i></p> <p><i>We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain.</i></p> <p><i>Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.</i></p>					
	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1. I worry all the time about whether the pain will end	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. I feel I can't go on	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. It's terrible and I think it's never going to get any better	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. It's awful and I feel that it overwhelms me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. I feel I can't stand it anymore	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. I become afraid that the pain will get worse	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. I keep thinking of other painful events	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. I anxiously want the pain to go away	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. I can't seem to keep it out of my mind	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. I keep thinking about how much it hurts	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. I keep thinking about how badly I want the pain to stop	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. There's nothing I can do to reduce the intensity of the pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. I wonder whether something serious may happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

ESSI (Social Support Screening Tool)					
<i>Please read the following questions and check the response that most closely describes your current situation:</i>	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Is there someone available to you whom you can count on to listen to you when you need to talk?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Is there someone available to give you good advice about a problem?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Is there someone available to you who shows you love and affection?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Is there someone available to help you with daily chores?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Are you currently married or living with a partner? <input type="checkbox"/> Yes <input type="checkbox"/> No					

PC-PTSD-5 (Post Traumatic Stress Disorder [PTSD] Screening Tool)		
<p>Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: <i>a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone killed or seriously injured, or having a loved one die through homicide or suicide.</i></p> <p>Have you ever experienced this kind of event? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <i>no</i>, please stop here and go to the next page. If <i>yes</i>, please answer the questions below.</p>		
In the past month, have you ...	Yes	No
1. had any nightmares about the event(s), or thought about the event(s) when you did not want to?		
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?		
3. been constantly on guard, watchful, or easily startled?		
4. felt numb or detached from people, activities, or your surroundings?		
5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?		

Adverse Childhood Experience (ACE) Questionnaire		
<p><i>Many people have experienced stressful events as children.</i></p> <p><i>These events may have an impact on long-term physical and mental health.</i></p>		
While you were growing up, during your first 18 years of life:	Yes	No
1. Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?		
4. Did you often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were you parents ever separated or divorced?		
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
9. Was a household member depressed or mentally ill or did a household member attempt suicide?		
10. Did a household member go to prison?		

Women's Urology and Pelvic Health Center | Patient History Questionnaire

Female Sexual Function Index (FSFI)

Instructions: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions, the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, masturbation, or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanted to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
 - ☐ Almost always or always
 - ☐ Most times (more than half the time)
 - ☐ Sometimes (about half the time)
 - ☐ A few times (less than half the time)
 - ☐ Almost never or never
2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?
 - ☐ Very high
 - ☐ High
 - ☐ Moderate
 - ☐ Low
 - ☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?
 - ☐ No sexual activity
 - ☐ Almost always or always
 - ☐ Most times (more than half the time)
 - ☐ Sometimes (about half the time)
 - ☐ A few times (less than half the time)
 - ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?
 - ☐ No sexual activity
 - ☐ Very high
 - ☐ High
 - ☐ Moderate
 - ☐ Low
 - ☐ Very low or none at all
5. Over the past 4 weeks, how **confident** were you about being sexually aroused during sexual activity or intercourse?
 - ☐ No sexual activity
 - ☐ Very high confidence
 - ☐ High confidence
 - ☐ Moderate confidence
 - ☐ Low confidence
 - ☐ Very low or no confidence
6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
 - ☐ No sexual activity
 - ☐ Almost always or always
 - ☐ Most times (more than half the time)
 - ☐ Sometimes (about half the time)
 - ☐ A few times (less than half the time)
 - ☐ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated (“wet”) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated (“wet”) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication (“wetness”) until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax?)

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

Thank you for completing this questionnaire